# BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

**Cover**

Health and Wellbeing Board(s)

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| Croydon |

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care.
Bodies involved include:

- SW London Clinical Commissioning Group (Croydon Borough)
- London Borough of Croydon
- Croydon Health Services
- Age UK Croydon
- South London and Maudsley NHS FT
- Croydon GP Collaborative.
- Local Care agencies, including care providers and care homes

How have you gone about involving these stakeholders?

Stakeholders have been involved via the One Croydon Alliance groups such as: the BCF working group, Localities Board, The Commissioning and Population health Management group and the Senior executive Group. This has included colleagues from Health, Social Care and Housing.

**Executive summary**

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

This document sets out Croydon's Better Care Fund Plan for 2022/23. It complements the BCF Planning Template which will be submitted together with this narrative.

This BCF narrative document and the Planning template will show that Croydon BCF plan for 2022-23:

1- Has been jointly agreed between health and social care partners. This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. As outline in the next section of this document the One Croydon Governance has been used to agree the plan, which will then be signed off by the Health and Wellbeing Board.
2- Includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £11.3M which is the minimum requirement.
3- Includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £16.7, in excess of the mandated minimum of £8.35M.
4- Makes a significant contribution to enabling people to stay well, safe and independent at home for longer, whilst also striving to provide the right care at the right time in the right place. This is through a programme of work centred around developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care, underpinned by a proactive and preventative approach using population health management to tackle health inequalities and target people whit the highest needs.
5- As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on July 19th 2022.

Our joint priorities are outlined in section 3 ("Overall BCF approach to Integration"). Our plan for 2022-23 builds upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and Social Care which outlines a vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people. The plan emphasises three clear priorities:

- Focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.

- Unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.
- Develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community

In Croydon, we are implementing this plan via the One Croydon Alliance, which is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning to improve the lives of older people in Croydon. The Partners in this Alliance are: Croydon Council, SW London ICB (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust and Age UK Croydon.

In 2014, Croydon Council and Croydon Clinical Commissioning Group (now SW London ICB) recognised they faced a common challenge to improve services for older people in an environment where demand was increasing, and resources were reducing. They agreed to work together to establish an Outcome Based Commissioning (OBC) framework to develop services for people over 65.

In April 2017, local partners formed an Alliance and signed a 1-year transition plan (the Croydon Alliance Agreement) which was followed by a further 9-year extension signed in March 2018. Initially, the Alliance focused on older people and developed the Living Independently for Everyone (LIFE) service as well as setting up the GP Practice based Multi-Agency Huddles and Telemedicine in Care Homes. The Alliance has now extended its work to all adults and the direction of travel is that eventually the whole population will be in scope for Alliance working.

The Alliance vision is to support the people in Croydon to be independent and live longer, healthier and fulfilling lives and be able to access high quality care, in the right place and at the right time, thereby reducing health inequality in Croydon. The aim is to achieve this vision while realising financial sustainability in the system and maintaining improved outcomes.

Previous BCF plans for Croydon focused on delivery of improved integrated community services that enabled people to receive the care they need at home or close to home. In so doing, reduce demand on acute health services and help maintain their independence and, as a consequence, reduce dependence on statutory services. These services included:

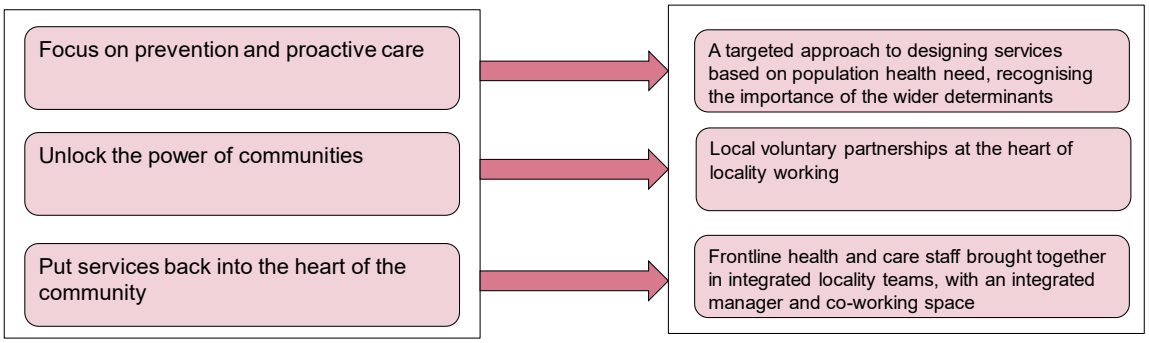
- Multi-Agency Huddles (including social workers) which are practice based
- LIFE service (Living Independently for Everyone)
- Community Diabetes Service
- Falls Service
- Community Based COPD Service

- Community Based Cardiology Service
- Accessible Mental Health Service
- Mental Health Reablement
- End-of-life care

All these service initiatives were supported through a range of other enabling projects including assistive technology, carer support, housing service, as well as additional social work support in working with the hospital to avoid admission to hospital through emergency care and facilitate timely and safe discharges.

Most of the BCF schemes in 2022-23 have been rolled over from 2021-22 but the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 and feed into the Localities Programme of integration in Croydon.

We have built on previous plans to take into account the increased emphasis on maximising independence and outcomes for people discharged from hospital via our Croydon LIFE service. As well as the development of our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon. This is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the localities of the borough. One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.




We are continuing to strengthen Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that will join up acute frailty care with frailty care in the community. Other key changes are the additional investment in Discharge to Assess processes in Croydon, to enable this to continue. Additional social work staff are funded also in the acute wards to facilitate discharges from acute elderly ward and palliative

**Governance**

Please briefly outline the governance for the BCF plan and its implementation in your area.

On 1 July 2022, we launched South West London (SWL) Integrated Care System (ICS) as we take on health and care statutory responsibilities in line with the new legislation, outlined in the 2022 Health and Social Care Act. It is envisaged that the introduction of the SWL ICS will only strengthen the already established One Croydon partnership as well as further ensure that local people receive the best care.

In preparation for the migration to ICS One Croydon Alliance introduced a number of whole system groups, including that of the Commissioning and planning group. This addition has allowed One Croydon the opportunity to strengthen the BCF management and oversight. In order to maximise the opportunity new governance has been installed, that have made the below amendments to the BCF S75 as well as the appropriate Terms of Reference.

**Health and Well Being Board**

Croydon Council's constitution has changed from an Executive Leader and Cabinet Model, to a directly elected Mayor, and in May 2022 the residents voted in a new Mayor. The changes to these decision-making arrangements have had implications on other Boards creating some delays to some governance as the amendments to the constitution are made. During this time, the June 2022 Health and Well Being Board was cancelled, the next scheduled Board is in October 2022. There are no delegated powers outside of the Board, and as such this is the closest opportunity to sign off the 22/23 BCF plans in Croydon. However, proposals will be made at this Board meeting to amend the Terms of Reference to the Board to the BCF plans in future will be able to delegated to key decision makers and the plans brought the Board for ratification.

**BCF Executive Group & SEG:**

Under the previous S75 agreement, final BCF signoff was to be completed by the BCF executive board. However, as the key members of this executive board already sit within the Senior Executive Group (SEG), within the current one Croydon governance it was proposed and agreed that the BCF executive boards functions are subsumed into SEG. SEG reports into the Shadow Health and Care Board, which feeds into to the Croydon Health and Wellbeing Board.

**The role of the Commissioning, Planning and PHM:**

With the introduction of the Commissioning, planning & PHM group, there now exists a governing board that can apply oversight to BCF requests and proposals prior to final agreement by SEG. Although not responsible for drafting proposals the group will now be responsible for discussing and approving proposals with all relevant One Croydon professionals.

**Introduction of the BCF working group:**

To facilitate the process of reviewing, planning and developing BCF spend options, a new BCF working group has been formed by commissioners and finance personal from health and social care. This group includes from across Croydon, Finance leads, Commissioners, Head of Improvement and Policy, One Croydon leads and the DFG lead. The groups report to the Commissioning, planning & PHM group quarterly with all reviews, options and proposed changes prior to any final submission.

**Joint Priorities and the Croydon Health and Care Plan**

Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance. Moving forward and with the introduction of the ICS, Place-based partnerships will remain as the foundations of integrated care systems building on existing local arrangements and relationships. Place has four main roles, all of which One Croydon has been delivering since 2017:

- To support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods.
- To simplify, modernise and join up health and care
- To understand and identify people and families at risk of being left behind and to organise proactive support for them; and
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Following 2020/21 and the COVID-19 pandemic a new refreshed plan was needed as a response from health and social care. This refresh has given One Croydon the opportunity to come together and assess our progress so far and what our priorities need to be in a fast-changing environment including emerging impact of the pandemic, the Health and Care Bill and the Local Authority financial position.

**Overall BCF plan and approach to integration**

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- describe any changes to the services you are commissioning through the BCF from 2022-23.
- How BCF funded services are supporting your approach to integration. Briefly

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As such, additional aims for 2021 to 2023 have been included:

- Support Croydon people to recover from the effects of the pandemic, through the recovery programme and a focus on high quality care
- Support, develop and maintain the Croydon health and care workforce
- Lead a determined, collaborative approach to tackling inequalities
- Embed a Population Health Management Approach

**Approach to collaborative commissioning**

In the last year, we have strengthened our commissioning partnerships with communities and the voluntary and community sector. A 'Healthy Communities Together Model' is in development, with 6 local areas, each area has a lead from the voluntary and community sector. The ambition, is to enable a stronger voice for all

voluntary sector organisations within Croydon, creating a shared leadership model with partners. As part of this, a locality-based commissioning model is being created, with the principle to shift spend and activity into the Voluntary community sector over time. This is to be informed by an evidence-based approach to improve outcomes, manage demand and better value. Scoping of potential contracts that can be delivered by the sector and a locality- based process for grants allocation are in development.

We have also strengthened our collaborative commissioning work between the Council and the ICB. For example, the recommissioning of the BCF funded End of Life Respite service. This is commissioned by the ICB. The aim of this service is to supports people to die at home if that is their preferred place of death whilst reducing the risk of A&E/Hospital admission if a carer enters a crisis.

The contract ended on 30st September 2021. The ICB team in Croydon worked closely with the Council team to undertake a mini-tender for a new contract to begin on 1st October using the Council's Dynamic Purchasing System (DPS 1) to procure a new service. The evaluation panel was clinically led and involved 2 GPs, as well as colleagues from the Council, ICB and procurement team. The mini tender was successful, and a new provider identified. This was the first time the ICB used the Council's DPS for procuring a service collaboratively.

Placement is another area where there have been good opportunities for collaborative working. Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. The Council and the ICB's CHC team are working in partnership to develop the Care Home market, especially Nursing Homes. A few examples of how we work collaboratively in commissioning include:

- Establishing a Care Home Strategy Group with key partners including Council, CHC, ICB and other health partners.
- CHC supporting and placing residents on D2A pathway 3 into Nursing Homes
- Looking at market trends for ongoing commissioning pathways
- Providing dedicated support and training to care homes through various mechanisms including dedicated webpages, webinars, training sessions, recruitment campaigns etc.
- Working together to commission future intermediate care beds provision in Council owned Care Homes. (BCF funded).

**Changes to previous BCF plans**

Most of the BCF schemes funded in 22-23 have rolled over from 21-22. The ethos however has been to build on the integration work that Croydon has implemented since 2017 through the One Croydon Alliance of health and care. The schemes feed into, and enhance much of the ICN+ programme of integration and the six localities in Croydon. Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.

All adults in Croydon (>18) are in scope for our initiatives.

Other changes to the plans are in relation to support the emerging Frailty Strategy, aligned with the ICN+ model. The strategic objectives are:

- Strategic objective 1: Clinical Frailty is recognised as a condition which needs to be addressed as part of a holistic approach to identifying and addressing people's wider needs.
- Strategic objective 2: People identified as living with frailty will experience improved outcomes through better access to appropriate interventions at the right time and in the right place.
- Strategic objective 3: Better use of resources by early identification, proactive intervention and improved care planning.
- Strategic objective 4: To always adopt a patient centred approach by engaging with people living with frailty and their carers, to understand what matters to them.
- Strategic objective 5: People are empowered to understand and influence their own care, through better communication, education and self-management.

As part of this work, and delivered through joint BCF and Aging Well (Anticipatory Care) funding, we are implementing additional capacity through two Advanced Frailty Practitioners to support the Acute Care of the Elderly (ACE) team to identify and review patients in ED, supporting transfer and care through a frailty SDEC and virtual ward (both currently under review and further development) and into the community as appropriate to avoid admissions wherever possible. The 'front door' focussed roles will work with the newly appointed ACE Interface Consultant who will focus on early support and intervention for older people in ED and SDEC.

In addition, changes to the current Complex Care Support Team are in progress to refine the current band 7 roles (3 WTE) and, including a further 3 additional WTE roles, to undertake locality based Frailty Practitioner roles. Thereby ensuring embedment in local neighbourhood teams as part of the ICN+ arrangements.

The additional frailty practitioner roles and advanced frailty practitioner roles are currently being finalised with the aim of recruitment being completed by December 2022. Full mapping of current services and the new roles is to be undertaken shortly to ensure clarity of roles and responsibility and enhanced joint working across primary care, community, ED and acute, and social care through the ICN+ MDTs.

Engagement on local frailty services is to be undertaken in September 2022, to inform how we deliver the strategy and support people in the best way to meet their goals for independent living, including reducing the exacerbation of frailty. This work also aligns with the development of community - based schemes through voluntary sector partners to support earlier identification of frailty, provide appropriate exercise classes and support, as well as basic health checks.

Additional funding has been allocated to existing Falls Prevention scheme delivered by Age UK Croydon to work with people at home to reduce the risk of falls. Referrals had become increasingly complex. The additional funding has enabled the service to be more sustainable and the services has good outcomes with reduced the call outs for LAS, A&E attendances, hospital admissions, and reablement packages.

**Challenges to integration**

Some of the key challenges we are facing for integration are:

- the ability for Health services and Council services to integrate IT systems to allow systems to communicate securely and allow for data interoperability
- Wider system pressures, including relatively high bed occupancy in hospital and sustained increased hospital discharges, with additional costs on packages of care
- Risks to the delivery of BCF plans due to the already challenging financial position of Croydon Council
- Workforce recruitment, retention and wellbeing. The pandemic has put sustained pressures on staff in health and care, compounded by shortages of qualified professionals
- Estates. There are many examples of integrated teams working together. However, there are issue in Croydon with where to put these teams. The pandemic has helped facilitating remote working but for effective team development having some shared spaces is important particularly for multi-agency working and relationship building.
- Covid-19 and winter pressures are expected to create extremely challenging conditions over the next few months. Many of our schemes have been very effective during the pandemic and demonstrated the power of collaborative working in getting through a crisis. However, we cannot underestimate the risk to delivery of our ambitions due to these significant pressures.

**Implementing the BCF Policy Objectives (national condition four)**

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

**Enable people to stay well, safe and independent at home for longer**
As in previous years and building on the work of the One Croydon Alliance to deliver the ambitions of the Croydon Health and Care Plan, we want people to continue to experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence. The overarching approach to integration continues to be via the development of integrated care services that:

- help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates.
- help to keep people with one or multiple long term conditions and complex needs stable.
- allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate;
- support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
- provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence
- support and provides education to both family and carers to ensure their health and well- being needs are met, and includes support to maintain finances and staying in work, where relevant
- help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

The key programme funded through BCF that Enable people to stay well, safe and independent at home for longer is the ICN+ programme

<u>ICN+</u>

The One Croydon flagship programme, the Integrated Community Network Plus Programme, has established an integrated community health and social care service that comprises of Adult Social Care, Croydon Health Services, Mental Health and the voluntary sector within each of the 6 localities that make up the borough of Croydon. The integrated teams enable information sharing, joint assessment and care management. The service model ensures a one name, one budget, one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes.

Services under ICN+ localities are as follows:

- Community nursing
- Adult social care over 65s
- Adult social care under 65s
- Therapy services
- Age UK Personal Independence Coordinators (PICs)
- Mental Health PICs

- Named person for smaller community services e.g. Diabetes
- Link with Housing and other Council services

The ICN+ model aims to support people to stay well rather than treat them when they become sick. It focuses on preventing people developing long term conditions, such as diabetes or depression. If people have a condition, we work with them to stop it from becoming worse, thus reducing the number of avoidable hospital admissions. We recognise that physical health and mental health go hand in hand. Therefore, if we focus on preventing people from becoming lonely and social isolated, we will support them to stay independent and healthy.

Furthermore, access to support can also be accessed via Community Hubs, formerly known as “Talking Points” in the community. Health, social care and voluntary sector staff attend the Community Hubs to provide the required support.

The strength/asset- based, community-led support approach is adopted by all staff at the Community Hubs. Staff talk to people about what is important to them and explain what assets are available within local community to support them. The Community Hubs also provide advice about healthy living, housing and benefits. There is also access to a social prescriber and ongoing support from our well-established Personal Independence Service provided by Age UK Croydon.

<u>Community Led Support</u>

Croydon Place introduced Community-led support across discharge teams. Staff have received training on the ’good conversation’ tool. The training which, enables them to offer community support and non-funded solutions at the point of options being discussed with patients and families. The Community Connect map will be used as a first point of contact and on triage to inform available alternative options at every conversation with the person. Key features of this approach are:

- No decision about a patient’s long term care needs should be taken in an acute setting
- Follow up assessment and care should be timely and pro-active in the post-acute recovery phase with links to on-going community support
- Improved patient outcomes and experience at each part of the acute urgent care pathway and timely options for discharge with the appropriate assessment for “home” in the appropriate setting
- Care at home wherever possible with a view to enabling people to remain safe and independent in their own homes for as long as possible
- Review the emergency readmissions data over 50s to identify support within the integrated locality teams (ICN+) that could prevent readmissions
- Review the number of placements in the last 6 months to see if they could have gone home and they had received night sitting

**Provide the right care in the right place at the right time**

A significant proportion of the BCF funding is allocated to supporting hospital discharges via the LIFE service. The LIFE service is an integrated community-based team comprising staff drawn from across health, social care and the voluntary sector.

It provides intensive, proactive and goal-focused support for up to 6 weeks at times of high levels of need, when individuals require more clinical and social care interventions thereby preventing unnecessary hospital admissions or facilitating early supported discharge from a hospital ward, focussed on enabling the person back to the optimum state of wellbeing, functioning and independence (Reablement, Rehabilitation, Recovery).

As part of the One Croydon programme of work to review and improve the LIFE service, joint plans are discussed and agreed in relation to the discharge programme between ICB, LA and the local NHS Trust.

The service consists of the following elements:

1. Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
2. D2A pathway which includes a Trusted Assessor model, where Social Care and Therapy staff undertaking a single integrated assessment covering elements of both health and social care. The D2A model is used for all hospital discharges when care and support is required.
3. The LIFE service operates 7 days a week, 365 days a year. To support discharges from hospitals, brokerage and social workers have moved to a 6-day coverage (Mon-Sat). This is based on the pattern of discharges during the week, which shows most discharges happening on a Friday. During the height of Covid, some of the social work capacity was moved to support D2A in the community.
4. Hospital-based social workers are part of the hospital discharge MDT meetings. There are also twice weekly morning calls attended by staff from the LIFE D2A team, recently extended to daily, where operational issues are discussed, and plans agreed. As per the national discharge guidance action cards, acute colleagues complete a D2A referral form (Part A) providing information on the type of support needed for discharge, as well as a limited functional assessment. This information is used to provide the resident with an interim care package to support safe discharge and settle the resident home. This is followed by a Part B assessment in the resident's place of residence; the Part B assessor assesses and co-ordinates the recovery care package, liaising with therapy/reablement and other care providers, as appropriate.
5. The LIFE Service will continue to work on developing stronger relationships with the locality ICN+ teams to ensure residents who need low level support, e.g., exercise, be-friending, etc, can access using existing community assets, to maintain their health and well-being and prevent readmission.

To support achievement of this ambition a few new schemes have been developed with the principal acute trust serving Croydon, Croydon Health Services NHS Trust (CHS) are currently being put in place locally or with existing schemes bolstered:

- the local discharge team has been reviewed and redesigned to ensure more timely and effective discharges from the wards.
- Out-of-hospital schemes supporting the targets include an increased focus on and support for reablement and Home First functions and the continued success of our Virtual Ward model led by Rapid response

In line with other years, Croydon place over the next few months of winter some additional resources will be put in place to support safe, timely and effective discharge; improve the quality of discharges and avoid re-admission to hospital.

- Supporting ward staff. Providing dedicated staff from the LA in supporting D2A from wards with home first principal and focusing on Pathway 0 where possible with support from partner agencies. Providing 3 staff per day working directly with ward teams.
- Increasing voluntary sector support to help discharge and prevent re-admission. Increase offer of voluntary sector such as Age UK and Red Cross in providing enhanced support for people when they return home to help them for 2 weeks to regain independence and prevent re-admissions.
- Using assistive technology and staff to prevent hospital admission. Using assistive technology to support this and provide crisis support for short term period.
- Emergency home care packages of care to prevent admission. 7 days funding for emergency cases to prevent hospital admission whilst long term support/care is provided. This may include waking night support if required.
- Using ICN+ to check on most vulnerable residents to prevent admission. ICN+ winter check on clients over 85 on what they have in place for winter. Ensuring everyone who is being discharged is discussed at a multi-agency GP huddle and reviewed by the ICN+ team.
- Supporting staff training to maximise independence of residents and prevent hospital admission. Training for the current staff on developing assessments and person-centred goal setting. Also supporting and enabling positive risk-taking to maximise independence.
- Educating and support residents. Campaign on educating more people on staying well and warm. Getting neighbours to look after each other.

**A Hospital Only Discharge Programme** has been established this year, to ensure appropriate focus is given to internal hospital arrangements for discharge. The workstreams include, medical leadership of flow, planning for discharge from admission such as ensuring all patients have an EDD set following 24hrs of admissions which is communicated to patient, family and carers and ensuring

functional and social status has been assessed within 24 hours of admission. There is work on optimising Board round/ Ward round and MDT processes and expanding and developing the Integrated discharge team. Other areas of focus are further embedding of 'Patienteer', workforce plans for therapy, medical and nurse staffing to develop role diversification and move to 7 day working. There are clear timescales and clear expected impact metrics such as reduction in bed occupancy, increase in frailty assessments, increase no of discharges by 1PM. Some of these areas of work are reflected it the High Impact Change Model summary below.

**High Impact Change Model- Action Planning Template**

| Impact change | Where we are now | What we need to do |
|---|---|---|
| Change 1: Early discharge planning | **Established:** Integrated Discharge Teams (IDT) have been implemented in Croydon University Hospital (CUH). Discharge planning takes place much earlier and decision making based on the wards. Red bag scheme is used known and used confidently throughout wards. Full time red bag co-ordinator in post to develop/ improve/ embed the scheme. | Further develop the IDT team members- improving knowledge of discharge pathways, roles and responsibilities. In particular, on the wards.<br><br>To move towards discussing discharge planning at the point of admission. |
| Change 2: Monitoring and responding to system demand and capacity | **Established:** Patienteer bed management technology is in implemented in CUH and is used routinely. Daily huddles of IDT, discuss long stay patients, discharge co-ordinators on the wards. Clear escalation points- flow chart guide. | Continue to improve usage as a traffic light system and to be used more strategically in reporting. Develop with staff to update the system more routinely in real time. |
| Change 3: Multi-disciplinary working | **Mature:** IDT implementation with full cross section of professions represented. Daily huddles of IDT. ICN and ICN+ in the community | Further develop the huddle arrangements and increased involvement with GP's |

| | | |
|---|---|---|
| | continues to develop. Therapy staff engaged earlier on the wards. | |
| Change 4: Home first | **Mature:** D2A standardized policies and processes in place. Home First Policy is embedded. | To involve therapy earlier in process to support home first principles. To continue to develop consistent processes across SWL. Developed a pilot 'Placement in Principle Panel' – ad hoc panel called so every option is considered prior to long term placement agreed. Starts 5/9/22. |
| Change 5: Flexible working patterns | **Established:** Rapid Response, AED reablement hospital and community teams 7 day working. Assessments over weekends and discharges over weekend but less than in the week. | Role diversification for therapy and nurse programme to support 7 day working in the hospital. Primary Care Enhanced Access roll out in October 2022. |
| Change 6: Trusted assessment | **Established:** LIFE trusted assessor model is established- lower level equipment needs implemented to reduce therapy bottlenecks. Range of staff have accredited training | Monitoring process in place and outcomes. Discharge co-ordinators to support therapy D2A documentation. |
| Change 7: Engagement and choice | **Established:** Discharge policies clear, letter to patient/ family explaining and D2A, manage expectations. Red Cross support discharge | Developing ICN to use community assets and voluntary sector to support patients and reduce readmission |
| Change 8: Improved discharge to care homes | **Mature:** CH work well with discharge teams and facilitate discharge. Discharge teams and brokerage teams work closely effectively. CH are supported across | Monitor any failed discharges and identify areas of improvement across the system. |

| | | |
|---|---|---|
| | the system, telemedicine 24/7, support from LIFE community teams. | Monitor Primary Care –Care Home DES of allocated GP's. |
| Change 9: Housing and related services | **Mature:** Homelessness team at CUH. SWL partnership worked at overcoming challenges with housing options. Toole developed with named contacts. Staying Put service has strong links with discharge team. | To further improve assessment on admission of housing status and work towards EDD. |

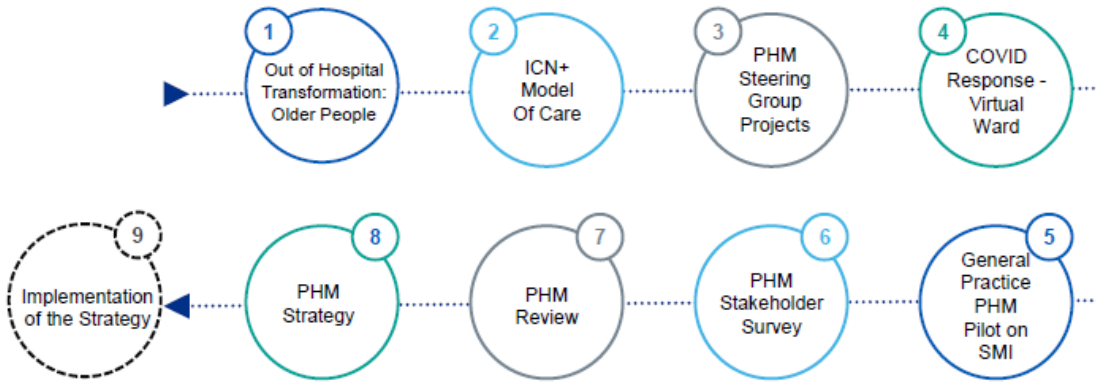
**# Plans for improving discharge and ensuring that people get the right care in the right place**

Population Health Management

Several projects in Croydon have already taken place with a PHM approach including the Out of Hospital Transformation and Integrated Community Networks+ programmes as well as identifying ways in which we could help those most vulnerable during the COVID-19 pandemic.

During the refresh of Croydon's Health and Care Plan in 2021 a commitment was made to develop a Population Health Management strategy; the first step was to carry out a stakeholder management survey and a review into how we use our PHM resources. The review and survey enabled the development team to identify key challenges that must be overcome in order to enhance how we use a PHM approach, and how we can have a greater impact on improving outcomes for people.

Below shows the journey Croydon place has taken so far in creating a new PHM strategy.




Croydon's PHM strategy was approved in May of 2022 and is currently being implemented into current infrastructures. The strategy and subsequent implementation planning considers the unique diversity of the borough as well

as factor in the multiple areas of deprivation that have a significant negative impact on health and wellbeing of Croydon Place. Furthermore, significant consideration has and will need to consider NHSE CORE20 population (defined as 20% of most deprived) which identified that 50% of the SWL Core20 Population reside within Croydon Place.

To meet these challenges, a cultural shift is being undertaken that shifts Croydon Place to being data-informed, rather than data driven. The difference being that we use data to inform our decisions in parallel with people's lived experience and community intelligence gained through our strong relationships with the VCS and newly established Local Community Partnerships. All of which, will delay implementation of a fully integrated and neighbourhood effective PHM programme.

It is hoped that by Q1 23-24 we will start to see the first neighbourhood interventions that should start to generate benefits by the end of the same financial year. It is the belief of the implementation team that these benefits will include better health outcomes with reduced care gaps and real-time monitoring as well as:

- Improved quality of care while reducing costs;
- Improved care for patients with chronic and costly conditions;
- Real-time access and closed gaps in care along with patient-centric view; and
- Better clinical outcomes.

<u>Anticipatory Care</u>

The neighbourhood ICN+ MDT model is currently being reviewed and refined against the national requirements of the delivery of anticipatory care as well as local learning. However, given the ongoing focus on supporting people with multiple Long Term Conditions, frailty and high usage of unplanned care services, this alignment is already significantly in place. Roles funded by the BCF, including new frailty roles, as well as 2 ICN+ Network Manager roles are aimed at ensuring:

a. early identification of need,
b. early intervention through community -based services, including e.g., personal independence coordinators, social care support and wider voluntary sector services,
c. continuity of care through GP MDT huddles into community MDTs and wider support services

In line with the Anticipatory Care PCN DES Contract and the overall Operating Framework (both currently awaiting release), review of the ARRS role's function is in progress. This is with the aim of supporting the development of personalised care plans including e.g., social prescribing where appropriate. In addition, a pilot population health management (PHM) project is in progress; with the aim of roll out to locality level (including PCN involvement) to refine the identification of cohorts needing focussed support / services locally in line with the complex and significant health inequalities across Croydon. Discussions are in progress between the leads of the PHM and Anticipatory care programmes to ensure alignment, which will be driven through learning from the current PHM pilot

**Supporting unpaid carers.**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Croydon Council commission the Carers Support Partnership to provide carer's assessment and other support services that aim to prevent, reduce and delay future needs for support. The Carers Support Partnership operates on a "hub and spoke" model in which Whitgift Foundation Carers Information Service runs the Carers Support Centre which is the "hub", and specialist services (Croydon Mencap and Mind in Croydon) are the "spokes".

The BCF contributes 21% (£109,000) to the overall contract value. Services in scope in the current contract include but are not limited to,

- The Carers Support Centre in central Croydon is the hub for carers' support that is easily accessible
- Information, Advice & Casework – through a range of methods such as telephone helpline, drop-in services, information packs and online directory services.
- Carers Assessment for adults (18+) – carers have the opportunity to talk about their caring role and get the right kind of support they need as a carer i.e. emergency planning, direct payments, respite etc.
- Allocation of carer's direct payment, accessed via the carer assessment
- Respite service – most carers who access this service do not make a financial contribution to their services and therefore the full cost of care would fall to social services. Carers have fed back that having an hour or two's break a week is something they can "hold onto" when their caring role becomes challenging.
- Health and wellbeing services such as the Carers Café, training and support groups, exercise classes and creative activities
- Counselling for young and adult carers
- Former carers support includes 1:1 bereavement counselling with a BACP registered counsellor and the Learning from Loss Programme

The performance of the contract is monitored and reviewed via regular contract monitoring reports and meetings with the service providers to ensure the service meets their targets and desired outcomes. Performance indicators include a combination of outputs (quantitative measures to assess the volume of activity) and outcomes (determinants of quality and the results achieved) indicators.

**Key highlights in 2021/22:**

1. Outputs
    - 690 adult carers assessments
    - 169 carers supported with home-based respite service
    - 213 carers received a one-off direct payment, amount ranging from £90-£1,250
    - 322 health and wellbeing sessions which were attended by over 2,100 carers
    - 1:1 counselling session to 137 carers

2. Outcomes (I statements)
    - 90% of carers felt better informed and supported.
    - 79% of carers felt better and able to cope with their caring roles
    - 89% of carers felt less isolated
    - 84% of carers felt their health and wellbeing have improved
    - 42% of carers agreed they had a break from caring (by attending the health and wellbeing sessions)

For End-of-Life Care, there are services to support unpaid carers, focussing on supporting people to have care within their home, if that is their place of choice:

- Marie Curie night sitting service – providing planned palliative care nursing covering a single patient in their usual place of residence who are in the end –o-f life stage of their illness. Cover is provided through short episodes of care delivered as appropriate to support the needs of patients and carers
- Carer Respite Service – provides a response support to the carers of patients (18+) of any diagnosis deemed to be within the last few months of life. The service complements the existing hospice at home services by providing their carers with practical, emotional, spiritual, social and bereavement support. This aims to reduce the risk of carers breakdown and crisis by providing a timely, responsive and reliable serviced to mee the changing needs of the carer and patient, as appropriate in the promotion of quality of life. Providing the carer with the peace of mind that their lived one is being properly cared for, while they benefit from time away from the care environment.

Croydon is committed to supporting carers by identifying carers at an early stage, assessing their needs and offering them appropriate support to prevent, reduce and delay future needs for support. The Carers Strategy 2018-2022 will be refreshed, and a review is underway to assess success, achievements, any further gaps to ensure it reflects the current landscape and needs of carers in Croydon. This strategy and will be used to inform future commissioning intentions.

### Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Ministry for Housing, Communities and Local Government allocation for Croydon for 2022-23 is £2,992,679.00.

The DFG is a mandatory grant which is subject to a means test. The criteria for this grant are set out in statute. Based on the current average spend of £12,000 per adaptation, the original budget could potentially fund 249 adaptations.

Key outcomes are:

- Provide access to suitable adaptations to help people to live as independently as possible in their own homes for longer.
- Allows people to self-manage long term condition(s) rather than rely on other forms of long-term support i.e., personal care using a level access shower rather than washed by care-workers.
- Prevent the need for costly residential placements, by provision of adaptations to help people use essential facilities within their home, move around the home and get into and out of the home.
- Improving safety of the home environment and prevents some unnecessary admissions to hospital or other clinical care settings because of lack of access to facilities in the home.
- People can stay living in their local communities for longer near to their support networks.

The DFG grant in Croydon is delivered under a Private Sector Housing Assistance Policy that is in place. The Policy was updated in July 2021 to reflect the government's guidance for the DFG process to be more flexible in its approach to providing adaptations.

As outlined above, in the key outcomes, The Policy is designed to assist 'owner occupiers' to keep homes in good repair, and enable older, vulnerable and people on low incomes to remain and live independently in their own homes. Our aim is to provide early interventions to prevent issues arising that would cost the ICS more money - invest to save. These include Adaptations and supporting Hospital Discharge.

Performance of the DFG feeds into BCF Governance Arrangements, the Joint Commissioning Executive and also imports into Croydon's Health and Wellbeing Board. The DFG is monitored monthly, with provision of activity, applications, approvals, timelines, completions and spend. These reports are overseen by the Head of Housing, the Capital Board and Executive Director of Housing.

There are long standing arrangements with the variety of Housing Associations, dependant on their size, on the contributions made to DFG in their properties, the

costs agreed in advance and then reimbursed by the Housing Associations, the links and the process works well.

As well as adults the DFG covers children with physical, mental and OR cognitive disabilities, which come via Health's Children's OT Service.

For the provision of Assistive Technology, it is the OT's responsibility to assess the need of the client and they will make the referral to the Assistive Technology Team to provide the necessary equipment.

Croydon's updated Private Sector Housing Assistance Policy, now includes a range of discretionary measures under the DFG to enable a more flexible approach to providing adaptations.

A Discretionary DFG, can now be given in addition to the mandatory DFG, totalling £60k. This facilitates major adaptations such as extensions to provide ground floor sleeping and washing facilities OR multiple adaptations through floor lift, Level Access Shower, Step Lift, Ceiling Track Hoists which exceed the current mandatory DFG limit of £30k.

There is an increasing demand for adaptations from Housing Associations. Options are offered to the HA's to enable adaptations for their tenants. One option is to agree that the HIA will project manage the work, and the HA provides a contribution towards the cost of work, or secondly the HA will project manage themselves with funding from the DFG. In 99% of cases, they opt for the HIA to project manage the adaptation work, for which a fee is charged. The larger of the HA's provide 50% funding, or a set amount towards the adaptation.

The DFG and our enhanced reablement services are provided through the in house Staying Put Home Improvement Agency. Our strategy with the enhanced service is avoid hospital readmission, and to enable people to continue to remain living safely in their own homes, and to increase their independence. We achieve this by providing a range of measures which include fitting key safes, through our Handyperson Service, to enable care packages following discharge. This service also does minor adaptations i.e., grab rails, stair rails, lever taps, fits lockable medicine cabinets, as well as mitigating risks of trip hazards by removing trailing wires, taping torn carpet. We also do blitz cleans, furniture removal to allow micro living, tackle hoarding issues, etc. By providing one or a combination of these measures enables a safe discharge and independence to the person, and aims to avoid hospital readmission.

**Equality and health inequalities**

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Croydon continues to face similar challenges as in previous years around health inequalities. The difference in how these challenges is addressed, is in the shift towards more locality working via the ICN+ programme and more targeted Population health management approach. PCNs are also addressing many issues around health inequalities using population health management and as part of the delivery of the PCN DES.

The Core20plus5 approach has enabled detailed analytical research across SWL ICB to examine who are our Core20. In addition to the plus 5 clinical areas, maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension, SWL as identified Diabetes as an additional clinical area that requires accelerated improvement. In anticipation of additional funding from SWL ICB to address health inequalities in Croydon a call for bids was made to commissioners and a prioritisation process established by One Croydon. The prioritisation and scoring process, led by clinicians, sought alignment with Core20, our Health and Care Plans and the likely impact. The approval of the selected prioritised work streams is now being finalised.

Alongside this, One Croydon has undertaken a series of actions that aimed to embed a strategic whole system approach to PHM, including: setting up a PHM steering group; developing a proactive and preventative framework; undertaking a BI review.

At a service level a PHM approach is routinely used in the development of new models of care and specific transformation projects i.e. ICN+, Diabetes. The ICN+ Model of Care is using a range of Localities Profiles maps which include health, social care and wider determinants data in order to understand the needs and health inequalities within localities so that resources can be targeted to address these. Further work is being done to pose specific questions for analysists to work on.

**Demographics**

Croydon's population is growing. The borough population recorded in Census 2001 was 330,587 and in the 2011 Census it had increased to 363,378. Based on ONS midyear estimates 2019, Croydon is home to 386,710 people and this is expected to increase to just under 500,000 by 2050. Croydon Council is the second largest of all the London boroughs in terms of population. Nearly a quarter of this figure (24.5%) is made up of young people aged 17 years or under. Around one in seven (13.8%) of our residents are aged 65 years or over. Croydon has the 4th largest proportion of young people in London which has implications on the types of services required to cater for the youth in Croydon. Like other London boroughs, Croydon has a higher proportion of residents from the BAME communities (especially Asian and Black communities) compared to the national average.

Croydon faces challenges around deprivation and inequalities in regard not only to income but other factors including health, education and housing. Over the last 4 quarters the number of households that were accepted as homeless has been over 2,000 over the year.

**Future Demand for Services**

People are living longer, and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds in Croydon by 2029. This is an important trend because we know that older people generally have more health

problems and are more likely to use health and care services. The number of older people living on their own in Croydon is increasing and a far greater proportions of older people living alone, aged 75 and over, are women. Social isolation and loneliness can have a detrimental effect on health and wellbeing and people living on their own can be more at risk.

**Health and social care market**

Croydon has a very high number of residential and nursing care homes in the borough (128). It admits a greater number of its residents to permanent residential placement than it would like to, meaning that residents are not moved onto more suitable longer-term accommodation. Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area. The services provided by homes within the borough have not been developed in alignment with the requirements of our clients and therefore do not always meet their needs. There is also the growing risk of provider failure, due to the rising costs of care, which the Council is committed to addressing locally.

**How inequalities are being addressed**

The ICN+ programme addresses health inequalities across the borough by adopting a targeted, Locality approach based on person-centred care and using strength-based approaches. Data is analysed to understand the location and nature of health inequalities across the borough. The programme has undertaken a basic population segmentation of the borough, with understanding of key groups, their needs and their resource use. This has enabled the networks to introduce targeted preventative interventions which contribute to support people to remain independent at home.

Key features of the ICN+ model are:

- Health and Wellbeing: Recognising that people's needs may not just be physical health related, but may include Mental Health, social care needs, housing issues and other wider challenges
- Supporting people to stay well: Proactive health maintenance in a community setting, to reduce urgent and unplanned hospital visits and increase peoples' experience of good health. There will also be access to social prescribing through Personal Independence Co-ordinators (PICs)
- Long-term conditions (LTCs): Identifying those at risk of developing LTCs, and focusing on helping people with LTCs to self-manage their condition and prevent acute episodes
- Multidisciplinary: A tailored team to address the specific local needs of the population, including Mental Health services and support for Social Prescribing
- Accessible: Locally-based and locally-targeted care, Health, social care and voluntary sector staff will attend the Talking Points to provide drop-in support, focusing on a range of health and wellbeing needs
- Proactive / Population Health Management: Using a Systematic Case Finding Model to identify people who may need support, rather than waiting for them to self-present in crisis

Overall Croydon has a higher prevalence of chronic and long-term illness such as diabetes and cardiovascular conditions in BAME groups which require ongoing support from primary and community services. In addition, many BAME groups experience barriers in accessing primary care services which leads to delayed treatment, increase in A&E attendances and hospital admissions, and therefore higher costs to the health and social care system.

In order to address these and other identified issues the ICN+ programme and services funded through BCF schemes have used population health data, gathered on a locality basis, is being used to tailor the model for each local network. Different localities need a different offer and therefore need different levels of resource.

Croydon struggles with significant gaps between estimated and reported prevalence gaps for Long Term Conditions including type 2 diabetes and hypertension. To address this, we are rolling out a community outreach programme with delivery of health checks and community awareness events; aligned with ICN+ model and building on joint work during Covid-19 pandemic with public health and voluntary sector organisations to engage with specific communities and develop culturally specific materials and information.

Obesity prevalence is variable between ethnic groups with some groups (e.g., Indian and Pakistani) over 5 times more likely to develop obesity. Obesity is a risk factor in a wide range of diseases (e.g., stroke, diabetes, CHD, hypertension). Exacerbation of these conditions can result in a need for emergency care.

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate and can lead to an increased risk of stroke. There are circa 2000 estimated number of undiagnosed cases of atrial fibrillation in Croydon. To address this, we plan to roll out systematic case finding service for of atrial fibrillation through our GP practices.

Many Type 2 diabetes patients and patients with hypertension struggle to meet the nationally recommended treatment targets. To address this, we plan to:

- Roll out an innovative new group consultations programme aimed at supporting patients with diabetes and /or hypertension to self-manage their condition more effectively.
- Roll out of a self-management programme called the Expert Patient Programme.
- Work with PCNs to deliver effective population health management strategies to provide proactive care to meet the needs of people with long term conditions.
- Support general practice to deliver the weight management directed enhanced service, which encourages practices to develop a supportive environment for clinicians to engage with patients living with obesity and diabetes and/or hypertension about their weight; ensuring effective referral pathways into local weight management services.
- Work with General Practice to onboard a further 2000 Croydon residents with non-diabetic hypoglycaemia (pre-diabetes) onto the National Diabetes Prevention Programme
- Embed of new integrated model of diabetes care in Croydon aimed at reducing the number of complications related to diabetes by investing in specialist service which would move the focus to prevention, early identification and improved

management of diabetes, with the specialist team working across acute, community and primary care.

Continue shift of care using virtual/remote monitoring for people with complex/multiple long-term conditions to be cared for at home rather than hospital using telehealth.

Work with ED and acute and community LTC specialist teams to develop and roll out new pathways for use of telehealth to avoid admission or facilitate earlier discharges.

Examples of BCF funded schemes that specifically tackle health inequalities identified locally include, the LIFE team and the additional funding for the Local Voluntary Partnership. The Life team within the community, support vulnerable and at- risk patients out of hospital, with provision such as telehealth, 2 hour crisis response, hospital at home, therapy services, discharge to access and reablement. These services including ICN + are described above under 'Provide The Right Care In The Right Place At The Right Time'. The Local Voluntary Partnership, builds stronger communities, through hubs, with a preventative, strength based, outcome focused approach. Opportunities and sources of support are offered to residents preventing crisis, but fostering independence and mutual support.

There are a number of BCF funded programs that directly support the Health Inequalities specific conditions identified in CORE20 plus 6:

South London and Maudesley (SLAM) NHS mental health provider are funded to provide a service that helps keep people of out hospital, following a comprehensive assessment for those in the acute phase of mental illness. SLAM is also funded through BCF in a community provision in the home, with short intensive support to keep people at home and to facilitate earlier discharge.

There are 2 diabetes services (as Croydon has included diabetes as a local challenge). A community diabetes service reduces the number of patients being managed in an acute setting and house bound patients are seen. Structured diabetes education helps patients better manage their condition and reduce complications.

A community COPD service provides spirometry, pulmonary rehabilitation and evidence - based pathways. The Edgecome unit has a COPD assessment provision preventing admission.

**Care Homes**

Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. Approximately half are Older People's homes and the rest are MD/LD homes. Given the scale of the challenge for Croydon in supporting this large number of care homes, access to services for Care Home residents has historically been variable as some services were not commissioned to cater for care home residents; whilst specialist services commissioned for care homes, especially LD and Mental Health, have always been extremely stretched. To address this inequity of access we are putting more investment into ICN+ so that residents in every care home can have the same level of access to locality services as any other

Croydon resident. We are also beefing up provisions for MH/Dementia and LD residents in care homes, whilst also working with the voluntary sector to put provisions in place to reach out to these cohorts of clients.

**Inequality of outcomes linked to BCF metrics**

BCF metrics are routinely monitored via our one Croydon system dashboard. Additionally, we have recently established a brand-new Croydon Population Health Management Group to look at a system-wide strategy for implementing population health management and addressing health inequalities across a spectrum of areas of work. We will ensure that BCF metrics are included to monitor any inequality of outcomes for the key BCF metrics.